New Patient Form **Welcome to our Office**

Date: ______________________________Driver's License Number (for ID purposes):________________________________

Patient Name: ____Social Security#______________________________

Patient's DOB: _____________________Current Age: _______Sex: _______ Preferred Language: ______________________

Race (Please Circle) African American Caucasian Asian Native American Latino/Hispanic Other

Ethnicity (i.e. Italian, Cuban, etc): ____

Marital Status (Circle one): Single Married Divorced Separated Widowed

Home Address: ____

City: ____State:___________________Zip Code: _______________

Home Phone Number: __________________________________Cell Phone Number: ______________________________

Email Address: ____

Is it okay to leave a Message on Your Home Number to confirm an appointment or to ask you to call back? Y N
Is it okay to leave a Message on Your Cell Number to confirm an appointment or ask you to call back? Y N

Employer: ____Work Phone Number: _______________________

Employer Address: ____

Referred by: ____
****

Name of Person to Contact in case of an Emergency: ____

Your relationship to that person: ______________________________

Address of Emergency Contact: ____

City: ____State: ________________Zip Code: _______________

Contact's Home Number: _______________________________Contact's Cell Number: __________________________
****

Primary Health Insurance Company: ____

Policy# ____Group#_________________________________

If you are NOT the Insured for your primary insurance, please fill out the following information:

Insured's Name: ____Insured's DOB: ______________________

Insured's Social Security Number: _________________________________Relationship to you: ________________________
****

Secondary Health Insurance Company: ____

Policy# ____Group# _________________________________

If you are NOT the Insured for your secondary insurance, please fill out the following information:

Insured's Name: ____Insured's DOB: ______________________

Insured's Social Security Number: _________________________________Relationship to you: _______________________
****

What Pharmacy do you use for Prescriptions?

Name of Pharmacy: ____Phone Number: ___________________________

Address: ____City: ____________________________State: ______________

New Patient Questionnaire

Name ____Age _______DOB________Today's Date________________________

What would you like to discuss with the doctor today?

Past Medical History- Please list any medical problems other doctors have diagnosed you with:

Please list any medications, herbs or supplements you are currently taking, along with doses:

Allergies to medication (please specify the medication and reaction, if known):

Past Surgical History:

Surgery	Year	What hospital?

Past Hospitalizations:

For what reason?	Year	What hospital?

Please list any other information that you think might help in your treatment today:

Patient Consent Form

I hereby give my consent for **Fairfield County Integrative Family Medicine, LLC ("FCIFM")** to use and disclose protection health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (**FCIFM's** Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy prior to signing this Consent. **FCIFM** reserves the right to review its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **FCIFM at 324 Elm Street, Suite 203A, Monroe, CT 06468**.

With this consent, **FCIFM** may mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **FCIFM** may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this Consent, **FCIFM** may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **FCIFM** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this Consent.

By signing this Consent, I am consenting to **FCIFM**'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this Consent, or later revoke it, **FCIFM** may decline to provide treatment to me.

AGREED:

______________________________________ ____________________________
Patient's Name Date

______________________________________ ____________________________
Patient's Date of Birth Patient's Social Security Number

____
Signature of Patient or Legal Guardian

Fairfield County Integrative Family Medicine, LLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, ___________________________________, have received a copy of the Notice of Privacy Practices.
Please print name

Signature of Patient: ____

Signature of Guardian, if patient a minor: ____

Date: _______________________________________

Insurance Authorization and Assignment

I request the payment of authorized Medicare/Medicaid/or other insurance company benefits be made on my behalf to **Fairfield County Integrative Family Medicine, LLC ("FCIFM")** for any services furnished to me by that party which accepts assignment and/or the physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financial Administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to me or the party that accepts assignment. I understand it is mandatory to notify the health care provider of any other party that may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 38/01-3812 proved penalties for withholding this information.)

I request that payment under the Medicare or other medical insurance program(s) be made to **FCIFM** for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by **FCIFM** from Medicare and/or other insurance company(ies), I will immediately endorse them and turn them over to **FCIFM** for services rendered.

I understand that I am responsible for payment of all charges and fees to **FCIFM** to which they are entitled to collect which are not paid for by Medicare or other insurance.

Signature of Patient/Guardian: ____ Date:_____________________

Consent for Diagnostic and/or Therapeutic Procedures

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunization(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Signature of Patient/Guardian:____Date:___________________

Prescription Renewal Policy

Fairfield County Integrative Family Medicine, LLC's physicians are available for emergencies twenty-four hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with a nurse between the hours of 8:30am and 5:00pm Monday through Friday. We will get back to you within twenty-four hours. By following this policy, we can assure you the highest quality of medical care. **Absolutely no medication refills will be made evenings or weekends.**

Patient Examination Room Escort Policy

To ensure your comfort, at your request, you may have an escort present with you during your examination. An escort may be a friend or a family member, or we can furnish a staff member to be present during your examination. At the physician's discretion, an escort may also be asked to be present at the time of the examination.

____ ______________________________

Patient Signature Date

Fairfield County Integrative Family Medicine, LLC

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party ____________________ Date ____________

Fairfield County Integrative Family Medicine, LLC

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: ____ Date of Birth: __________________________

Parent's Name (if patient a minor): _____________________________________ Telephone# ____________________________

I hereby authorize the release of my medical records from: ____

I hereby authorize the release of my medical records to: ____

I hereby authorize the individual/entity listed above to release my own or my child's records described above, including AIDS/HIV, psychiatric, drug abuse and/or alcohol related information if applicable and use of the information for the purpose of:

☐ At the request of the patient

☐ Other: ____

This form serves the dual purpose of a general authorization for the release of protected health information and a specific authorization for the release of information protected by state and federal confidentiality laws and regulations. The information to be released may contain information pertaining to mental health/psychiatric information, alcohol, drug and/or HIV or AIDS testing, diagnoses and treatment.

I understand that it is my right as stated in the Fairfield County Integrative Family Medicine, LLC (FCIFM) Notice of Privacy to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit this to FCIFM. I understand this revocation will not apply to the information that has already been released in response to this authorization.

I understand authorizing this disclosure of this health information is voluntary. I need not sign this authorization to ensure treatment, payment or healthcare operations. I understand I may inspect/copy the information to be used or disclosed according to state and federal law, and as stated in the Notice of Privacy of FCIFM. I understand information once released from this office may not be protected by HIPAA rules and carries with it the potential for an unauthorized re-disclosure.

____ Signature of Patient or Legal Representative

___________________________________ If Legal Representative, specify relationship

____ Name- Please Print

____ Date

___________________________________ Recorded/witnessed by FCIFM Staff

Fairfield County Integrative Family Medicine, LLC
324 Elm Street, Suite 203A
Monroe, CT 06468
Phone (203) 445-9060, Fax (203) 445-9093

Fairfield County Integrative Family Medicine, LLC

LABORATORY TESTS AND RADIOLOGICAL STUDIES

The doctor will attempt to contact you with your results once they are received and reviewed. This may include results for lab tests, x-rays, MRI's, CT Scans, and other radiological diagnostic testing. At times, it may be difficult for the doctor to reach you. We would like to know the following:

Is it okay to leave results on your home phone? Y N

Is it okay to leave results on your cellular phone? Y N

Please note: You may ALWAYS state at any time if you do not want a message left for any particular test results.

____ ____________________
Patient Signature Date

AUTHORIZATION TO TALK TO SOMEONE ELSE REGARDING TREATMENT OR BILLING

I, ____________________________, authorize any provider or member of the staff of Fairfield County
Print Name

Integrative Family Medicine, LLC to give information regarding my visit, treatment, laboratory or diagnostic test results, billing matters and any other information concerning my treatment to:

Person's name ____

Relationship to patient: ____________________________________

I can revoke this authorization in writing at any time.

____ ____________________

Patient's Signature Date

Fairfield County Integrative Family Medicine, LLC

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance: We participate in several insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services: Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment: If you account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments: Our policy is to charge for missed appointments not cancelled within 24 hours prior to the scheduled appointment. These charges will be your responsibility and billed directly to you, not to your insurance company. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Fairfield County Integrative Family Medicine, LLC

Advance Directive

What is it?
It is a statement that tells your doctor and family what care you would like to have when you are not able to make those decisions because of the seriousness of your injury or illness.

There are two kinds of Advance Directives:

- A Living Will
- Durable Power Of Attorney for Health Care

A Living Will- What is it?
It is a statement that lets you tell your doctor and family your wishes if there is no hope for your recovery and you become unable to make your own decisions. An example of this would be whether to continue to use a breathing machine to keep you alive if you were in a permanent coma following an automobile accident.

Durable Power of Attorney for Health Care- What is it?
It is a statement in which you appoint a person to make medical judgments for you if you become unable to make those decisions for yourself. That person should be someone you trust to make health decisions like the one you would make yourself if you were able. Usually that person would be a close relative or close friend.

Is one better than the other?
They are different and are used for different things, so they are both good. These statements are to help your family and your doctor make decisions concerning your health care at a time when you are not able to. You may use one or both of these forms of advance directives to provide direction for your medical care. You may combine them into a single statement that appoints a person to make medical decisions for you but also tells that person of your wishes if there is no expectation for reasonable survival.

Can I change my mind?
Yes! You can change your mind or cancel your statement at any time. Changes should be written, signed, and dated. You can also make your change of opinion by telling someone (an oral statement).

Who should make out an Advance Directive?
Because we may have a serious illness or injury at any age, all adults should have an advance directive.

NOTICE OF PRIVACY PRACTICES

Fairfield County Integrative Family Medicine, LLC.

324 Elm Street, Suite 203A

Monroe, CT 06468

Privacy Officer: Terry Scalora, office ph# 203-445-9060

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

B. When This Medical Practice May Not Use or Disclose Your Health Information

C. Your Health Information Rights

1. Right to Request Special Privacy Protections
2. Right to Request Confidential Communications
3. Right to Inspect and Copy
4. Right to Amend or Supplement
5. Right to an Accounting of Disclosures
6. Right to a Paper or Electronic Copy of this Notice

D. Changes to this Notice of Privacy Practices

E. Complaints

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a computerized chart in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official. Dr. Cremin has admitting privileges at St. Vincent's Medical Center.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for

purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. We will only use e-mail notification if we are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition. We would not send email to such an address.

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in

writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services, Office of Civil Rights, JFK Federal Building – Room 1875, Boston, MA 02203

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.